INFORMATION

Professional Problems in Federalized Health Care Abroad

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Introduction

Recent passage of Medicare legislation by Congress presents the American people with an entirely new approach to financing and provision of medical care. This significant step, while taken long after most other Western countries and many of the developing countries, is an indication of the ever-increasing responsibility assumed by the government in the financing of health care, regardless of need. Observation of many already established nationalized programs gives the United States the advantage of being able to learn from others' experiences and avoid their mistakes. Difficulties and discontent with organizational details of any program, its financial arrangements, distribution of authority and qualitative controls, still characterize most Federal programs.

The following discussion deals with some of the more frequent problems which aggravate federalized legislative enactments—problems which have thus far been met with lengthy political debate, periodic negotiation and occasional mass protest by physicians. No attempt is made to describe the various systems beyond their relevance to the particular problems they generate.

The specific problems to be considered in this discussion, listed in approximately the order of their occurrence within various socialized programs, are as follows: 1) Inadequate Physician Remuneration; 2) Decline of Professional Status and Subsequent Authority of Physicians; 3) Dominance of Political Decisions in Alloting Funds; 4) Bureaucracy of Federal Control; and 5) The Patients' Perspective: Impersonality of Care.

1. Inadequate Physician Remuneration

The problem of inadequate physician income has undoubtedly contributed more to the psychological weakening of the program than has any other problem. Physicians in many countries have in the past united in angry protest against their respective governments. The volume and nature of their demonstrations, referring to such cases as the mass strikes occurring in Belgium, Italy, France and Mexico, have won considerable sympathy among American physicians. The intensity of strife possibly induced further objections to facets of the program among the physicians, if not complete disenchantment with it.

GREAT BRITAIN

Recently, British physicians have had much to say on this subject. Dissatisfaction with salary increases issued this Spring by the government motivated Britain's GP's (numbering 24,000 out of 64,000 physicians in the National Health Service and 600 physicians who maintain a totally private practice), to become involved in the most serious crisis that has threatened the National Health Service since its inception in 1948. The GP's presented a united front and, on threat of resigning from NHS, demanded that the government pay them a minimum weekly average of $196 instead of the recommended $168.[1] Their argument that the standard of living of the GP in Britain had declined under the system by about one-fifth, while that of all other occupations had risen by the same amount, persuaded the government, after several bitter months, to offer a compromise acceptable to the GP's.

The immediate commotion subsided but its initial provocation, the system of remuneration in Britain, still threatens government/physician relations. The GP's recommend a new NHS system. As one part of it they ask for direct reimbursement for expenses rather than the fixed annual amount of $4,060 which is given to each doctor now, regardless of actual expenses.[2] A fixed amount encourages the GP's to spend sparingly and stay as far below this amount as possible, at the sacrifice of new and improved equipment, additional personnel and possibly good medicine.

Another change requested relates to the method of setting physicians' salary. The average GP salary is currently $7,742 after expenses but before taxes (average income in Britain is slightly over $2,000). This sum varies according to the number of patients a GP has on his list, which can range from 1,500 to 3,500 potential or actual patients, but averages about 2,300. The government pays a capitation fee of approximately $2.87 to $5.18 per patient each year, based on the cost of living, with various "loading" payments and allowances for "unpopular areas." The obvious complaint is that the GP's salary is unrelated to his work load, responsibility or quality of his work, except that a patient may elect to be on his lists. Physicians claim that about 1,500 patients is the maximum that can properly be attended, yet over half have more than 2,500 patients and 29 per cent more than 3,000.[3] A physician, therefore, who tries to offer conscientious care and personal attention to his patients must pay the price with a lower income. During an epidemic, or with a list of disproportionately older patients, one physician's work load will far exceed another's, though their incomes may remain equal.

The physicians, therefore, want the pool system of payment abolished in favor of fees for each item of work or straight salaries. The government has

thus far agreed to three conditions; provision of loans for improving practice conditions, reimbursement for office employees' salaries, and a reduction in required paper work.[4] No basic structural changes have yet been made.

Parenthetically, it should be noted that any physician in the British system may supplement his income with a private practice and that many do so. Although they do work harder, they are also better paid than most professionals in Britain. Lastly, despite their problems, the majority of the medical profession still is said to support emphatically a federally sponsored program of medical care.

MEXICO

Recent strife in Mexico inspired the whole medical profession to fight and some members to strike for an increase in pay for residents and interns. In many of the country's hospitals, most of which are run by government agencies, interns and residents are paid less than the minimum wage for unskilled labor, ranging from $20 to $148 per month in the Ministry of Health and $32 for the first year to $148 the fourth year in the Social Security Institute. The government, in addition, provides food, lodging, uniforms, and organizes teaching programs, which most students maintain are poorly organized. Young physicians want uniform raises to $96 per month for interns and $160 for residents with increments of $40 monthly for each succeeding year up to a maximum of five years.[5]

The three-month strike concluded with the government yielding to all demands; a wage scale of $120 to $256 per month for interns and residents and a 10 per cent cost-of-living increment. It also agreed to improve living quarters, supply adequate work clothes and reorganize deficient teaching programs.

Whether this will be enough incentive to curb the shrinking enrollment of medical students remains to be seen. The AMM (Alianza de Medicos Mexicanos) contends that "medicine, which is largely socialized in Mexico, no longer attracts young men because of the low pay."[6]

SWITZERLAND

While Switzerland has no nationalized medical program, it does provide private sickness insurance funds whose representatives negotiate with the physicians to establish a scale of fees and procedures, insuring that doctors do not use extravagantly costly drugs or treatments. Difficulty arose recently when supervisory activities were assumed by the Fund administrators over the physicians and fees were held down. Swiss doctors were likewise angry because they had to work up to 80 hours per week, did not get paid holidays, had to pay their own expenses when in the service and received no pension.

The system is decentralized, allowing individual cantons to decide on compulsory or voluntary health insurance. Eighty to ninety per cent of the people are members of these private insurance associations. The federal government subsidizes recognized private voluntary health plans, pays a fee-for-service and prescribes the conditions such associations have to meet to gain federal recognition. (Health insurance funds pay only a fraction of hospital expense, the rest being paid by the government.) These government-prescribed conditions primarily touch on questions of organizations, benefits, freedom of choice and relationship with the physician. The cantons are empowered to set fee schedules for compensation of doctors by the health plans, considering the arguments of both the medical profession and the insurance association. Fees are low, so doctors are able to make satisfactory incomes only by carrying heavy work loads, performing more technical and lucrative procedures (though they may be limited to specialists), and encouraging repeat visits to their offices. Recently the insurance association has tried to economize even further by holding down fees, and thus has caused the most recent difficulties.[7]

BELGIUM

One of the most widely publicized and intensely criticized and supported medical crises occurred in Belgium during the Spring of 1964. Physicians objected to a law passed by Parliament which awarded the government additional control over medical care, far more than the medical profession would agree to yield. While the conflict appeared to involve only a struggle for authority, a formidable objection lay in the inevitable cut in physician income which would result from the proposed measures. Physicians argued that the law "provided for a fixed schedule of fees to replace private fee arrangements between physician and patient . . ., would probably also result in higher taxes for doctors because fee receipts would give a central record of their incomes . . ., would turn independent physicians into civil servants; extend government control over the practice of medicine; restrict private practice to three half days a week; and violate the confidential relationship between doctor and patient." They complained of the threat to professional secrecy when patients were made to carry medical books and the threat to the doctor's right to give the treatment of his choice. The physicians demanded, and, with an 18-day strike, won, a guarantee of full control over the treatment of patients, free choice of physician by the patient and exemption of minor ailments from insurance coverage, to discourage unnecessary request.[8] They also received a raise in fee for surgery consultations, assurance that no schedule of fees would be effective without 60 per cent of the country's doctors contracting to work within the schedule, enough time for private practice and equal participation by doctors and members of the insurance organization on a National Committee.[9]

Belgium has had a compulsory health insurance scheme for workers below a certain income level since the end of the war, administered by several semi-official agencies attached to various trade unions and supported by members, employers, and government subsidies. The agencies decide the sums payable

to doctors on a fee-for-service basis and refund the patient about 75 per cent of this amount. However, there has been nothing to bind the physician to the standard agency rates, and most of them reportedly charged more without recording it, in order to avoid taxes on the extra amount. This scheme permitted physicians the full authority of a private practice and the security of patients and payments in a nationalized setting. The new law was intended to remove some of the authority—it only partly succeeded.[10]

ITALY

Italian physicians likewise tried to rectify what they felt was monetary injustice in an eight day strike in 1963. Officially, a hospital doctor's monthly basic salary may be as little as 43,000 lire (about $70), although unofficial estimates place it at about 93,000 lire (or $150) for juniors, excluding private work. The doctors demanded an official minimum (for those on salary, mostly specialists) of 150,000 lire ($250).[11] Forty-five thousand physicians participated in the strike against low fees (for those on fee-for-service) and red tape in government-sponsored medicine. The government agreed to raise fees 40 per cent (though doctors on fee-for-service had requested a five-fold increase), to reduce paperwork and to standardize fees.[12]

Eighty per cent of all Italians are either compulsory or voluntary members of one of several state-subsidized insurance plans for medical and pharmaceutical payments. Some general practitioners are paid on a fee-for-service basis, other general practitioners by capitation and most specialists by salary. Provincial officers negotiate the type of payment.[13]

FRANCE

Doctors in Paris staged a one-day strike this Spring decrying the government's refusal to raise their fees. About 30,000 of the country's 37,000 family doctors refused to sign any administrative form, certificate, or social security documents. While the government admitted that such a fee increase would not be unreasonable (an official survey found the physician's income below that of butchers or bakers), it stalled a decision, maintaining that constant fees in recent years have not prevented doctors from increasing their incomes. They have simply been working harder (60-72 hours per week) under a fee-for-service program. The physicians claim they are overworked already. One solution has been to enter group practice, a phenomenon becoming almost as familiar to French as to British doctors.[14] The physicians, dissatisfied with a 3 per cent raise in the fee schedule (they had asked for a 13 per cent raise), have threatened to withdraw from the social security system by October of this year if the government does not increase medical fees. Concern now centers on whether the medical scheme will become a political issue which will result either in the scheme's complete dissolution or in its complete nationalization.[15] This remains to be seen.

The French system of medical care is government-sponsored, compulsory for employees, locally administered and also provides sick pay. It is handled through competing health insurance companies. The French patient must pay doctor, hospital and pharmacist himself and then file for reimbursement from the compulsory health plans. If his physician is a participant in the scheme, the patient is repaid 80-100 per cent of his bill. If not, he receives only 25 per cent. Cost of these plans is financed almost entirely by heavy social security taxes on both employee and employer.[16]

NEW ZEALAND

Hospital specialists in New Zealand warned their government that hospital lines would grow even longer and standards of care would be threatened if they did not do something about hospital salaries. They asked for removal of a salary scale that keeps a high proportion of full-time hospital specialists graded at a low level. Raises depend, the specialists complain, "on the vagaries of bureaucracy." The government has called a meeting to prepare recommendations on medical salaries, but nothing has yet been settled.[17]

New Zealand has two other systems of payment for general practitioners and specialists in independent practice: the "refund system," under which the doctor can charge the patient whatever fee he wants, but the patient can obtain from the social security authorities, on presentation of receipt, only his fee-for-service; and the "schedule" system, under which the physician bills directly to the social security authorities the amount in the schedule, but can ask for more than that from the patient. Hospital staff members, as in most countries, receive a salary. Medical services are available to everyone and are financed from the Social Security Fund. The patient can choose his doctor, and the doctor can choose his remuneration method.[18]

CANADA

In contrast with the above-mentioned cases, Canadian physicians, particularly those in Saskatchewan, following their bitter struggle with government three years ago, say their earnings have climbed considerably since the government plan was introduced, due to the increased volume of service, reduction of patients who are entitled to free service (e.g., ministers, fellow physicians, etc.) and negligible collection problems.[19] In fact, contrary to the trend in every other country mentioned, the number of practicing doctors in the province has climbed to about 1,000, or nearly 100 more than before the program was introduced a couple of years ago. Saskatchewan has North America's first universal government-sponsored medical insurance plan. For $24 per family, every resident is completely covered against hospital and doctor bills. Private nonprofit agencies function in the administrative roles as a protection against government interference. Some physicians send their bills directly to the government, but most prefer

these collecting agencies or the patient himself. Regardless of which plan the patient selects—medical care plan, voluntary health insurance agency or neither—he is reimbursed up to 85 per cent of the schedule of minimum fees established by the Medical Care Commission.[20]

JAPAN

Discontent within the medical profession is mounting in Japan where physicians complain that they are the only professional group with a declining standard of living. Dissatisfaction with government handling of funds exists not only among physicians, but also among the debt-ridden health insurance organizations and the employee groups, all of whom object to a major rise in premium payments and the government's reluctance to subsidize chronic deficits. So far the discontent has been verbal only, allowing the government to remain recalcitrant on the issue.

Under a program adopted in 1961, about 99 per cent of Japan's citizens are covered by at least one of nine officially designated health insurance systems. The largest is the government-sponsored National Health Insurance Program, with a membership of approximately 45 million. Under the compulsory program, members pay a specified percentage of their incomes into a medical insurance program. Medical fees are rising and subsequent payment must come directly from the patient because the government refuses to pay.[21] Most governments contribute to this program as much as needed, having already collected it through income tax. The problem of who is going to suffer the losses in Japan as medical costs rise remains an open question.

2. Decline of Professional Status and Subsequent Authority of Physicians

While objections to this development are discreetly subdued, it is nevertheless fairly obvious that the physician's ego has suffered from what might be interpreted as diminution of status and transfer of functional role to that of a government functionary or worse, a clerk. The physician, in the most extreme cases of federal control, is no longer even the master in the practice of his own skills. This is made apparent when he is compelled to deliver control in medical matters into the hands of non-medical administrators, who neither understand nor sympathize with the problems of the physician.

Many American physicians have listed this inevitable and unacceptable government interference and control as the primary evil in the system. Examples of resistance to the distribution of authority are numerous. Strikers in Mexico asked that they be permitted to participate in the preparation of training programs. They demanded that medical personnel in government institutions be given the right to elect their directors, since politically appointed directors have often been unfair and unsympathetic to the medical staffs they supervise.[22] More equal dispersion of power is needed but is not feasible as long as the central government finances a substantial share of the expenditure. Doctors in almost all countries are urgently asking that more administrative functions be transferred to them.

In Britain and other countries, the government not only regulates the maximum fees which the physician charges, but also controls and periodically checks the drugs administered and prescribed to insure that the physician has not intentionally selected unnecessarily expensive drugs. According to one embittered British physician, a doctor is fined for being too experimental in his treatment or for prescribing too many expensive drugs. Bureaucrats who know nothing about medicine decide what drugs are on the list. "Always the government exercises stringent control to cut costs and to do everything as cheaply as possible."[23] The result is that physicians tend to prescribe safe drugs, excluding the newer, and therefore more expensive drugs. This interference in drug dispersion ultimately gives government a voice in the physician's relationship to his patient and creates a paternal surveillance of his diagnoses when drugs are involved. The issue of drug regulation is still very controversial: while one side argues its importance to prevent overuse of unnecessarily expensive drugs when cheaper ones would do, the other side resents, as mentioned, the intimidation and interference in professional practices by laymen.

Not only has the physician in general suffered status decline in some countries, but federalized medicine has also had the effect of putting the GP in the shadow of the specialist. For example, while specialists in Britain have a government salary, full hospital privileges and limited control by the state, GP's earn considerably less without the security of a salary and regular hours, must struggle with the government in their less clearly defined and predictable practice and are deprived of hospital privileges and thus the right to follow their patient's progress. They complain about serving as a mere intermediary between patient and specialist, a middleman to refer the interesting cases on to the better qualified. The typical GP operates in a confined neighborhood, prescribes for trivial ailments, and funnels serious cases to specialists in hospitals; he is never entitled to remain with a case just because it interests him. He has none of the advantages of regular hours and regular holidays that are enjoyed by his colleagues in the specialties. GP's must work out arrangements for cover when they want to take any time off. The GP's in Britain revealed far more than just financial dissatisfaction in their united resistance this Spring. Along with low status and middleman functions, they complained of professional isolation, long working days, too many patients, the position of pariah in the eyes of half the men in their own profession, and the demand that they refer the simplest ailments to specialists.

The British GP's therefore want to be admitted into the community of medicine, to share in the hospital treament of patients, to be given modern diagnostic aids, proper offices and staff, as the specialists.[24] They drew up a charter asking for a 5½

day week, overtime for evening and weekend work, six weeks holiday a year and direct repayment for expenses. They want to be able to choose between a flat salary, a fee per patient on the books, and a fee per item of service. So far the Ministry's only solution to the GP's isolation and excessive burden is to encourage group practice, thus giving the group a chance to work out a system for over-time and for holidays and to build specializations within the group.[25]

Physicians have worried a good deal about the depersonalization of the patient/doctor relationship as a result of their diminished control and status and having to treat too many patients. They argue that the patient must remain the central personage, but that he is in danger of losing this spotlight when doctors are paid by the fund rather than the patient. The patient is thus made passive in the transaction and completely unaware of the pressure exerted on doctors by the fund. Part of the Canadian problem dealt with what the doctors feared would be a dissolution of this special relationship with the current overflowing of doctor's offices and unnecessary use of facilities. In 1962, Saskatchewan physicians won world-wide attention in a 23-day strike protesting the government's denial of their participation in the design and approval of a comprehensive medical plan which gave the Premier almost total decision-making power over the type of medical plan, terms and conditions of physicians' services, payment, and other points. The government refused to amend the act, so they struck, not by refusing to provide care, but by providing free service. Public outcry forced the government to capitulate, and physicians completely revised the act. Fearing government control and supervision if forced to take money directly from it, they insisted on the continuation of voluntary nonprofit administering agencies as the intermediary agent, both as a face-saving device and a buffer against government. They also demanded private practice privileges and private voluntary programs to provide for both themselves and their patients the opportunity for freedom of choice. Only about 10 per cent of the physicians receive direct reimbursement from the government today.[26] While they admitted the necessity of some policing, the physicians asked that they be allowed to do their own, through the College of Physicians and Surgeons, which should have the further responsibility of licensing doctors, setting their fees and disciplining them.[27]

Although many feel that government control threatens the doctor/patient relationship, some physicians claim that nationalized programs have actually improved this relationship. They insist that while the physician cannot give each patient as much time as he would like, he is able to offer better and more complete treatment and is bothered by fewer hypochondriacs.[28] Some insist that the doctor/patient relationship is improved because the element of cost is removed.

3. Dominance of Political Decisions in Alloting Funds

One of the most serious difficulties that emerges in almost any nationalized medical program is the inevitable conflict between two groups both dependent on the same limited resources to fulfill their functions. This is the delicate balance and struggle between the Ministry of Finance (or equivalent) and the medical profession, over the exhaustible resource —the budget. The obvious advantage, by virtue of both control and proximity, belongs to the Ministry and it is the use of this advantage which has in the past forced the medical profession into dramatic actions of resistance. While the Ministry concentrates on balancing the budget with its own set of weights and measures, the medical field often suffers because medical expenses necessarily rise with a growing population, a larger elderly group, a higher standard of living, and new technology. As the Ministry weighs one national need against another, one pressure group against another, it is not surprising that the decisions have created severe shortages in the medical field. Annual budgets have been cut in financial crises in a way that is not compatible with good medicine. A shortage of hospitals and professional medicine men plagues almost every program. This is particularly true in Britain, where not one hospital was built for the first 15 years of the program, finally forcing the government to recently embark on a crash program of construction and rejuvenation. Long waiting lists appear on the records of all hospitals with sometimes as long as a year wait before patients can be admitted for elective procedures. Research fell far behind the United States and other countries and doctors were and are immigrating at about 500 per year to the United States and Canada where salaries are much higher. Almost one-half of 3,100 hospitals are operated by the NHS, but only five of these have been completed since the end of World War II. Two-thirds of the hospitals were built before the turn of the century.[29] The cost of the NHS in 1960 was 3.8 per cent of the value of all goods and services produced in Britain—at least a third less than the comparable cost of U.S. medical care that year and would have been still less if Americans could afford all the medical care they want.[30]

Likewise the shortage of physicians in Britain is still so severe that almost half of the emergency surgery is done by non-British trained doctors, primarily from India, whence a major portion of Britain's present medical staff originate. The number of students in training at present is below the 1938 level, a fact of considerable concern to the medical profession and the government. As Britain solves its doctor shortage with Indians, the Indian government is finding itself in the same predicament. Last year alone they had 3,000 vacant posts with pay so low and institutional facilities so limited that the Indians elected to immigrate to Britain. They complain that the Indian government demands and expects a "spirit of self-sacrifice," primarily monetary. In desperation

the government has clamped down on passport and foreign currency issuance to medical men.[31]

Many critics of socialized medicine protest the removal of medical care from a competitive market. British Professor D. S. Lees, a noted adversary of NHS, feels that medical care should be open to experimentation and innovation, that a tax-financed monolithic structure is "ill-suited to a service in which the personal element is so strong, in which rapid advancement in knowledge require flexibility and freedom to experiment, and for which consumer demands can be expected to increase with growing prosperity."[32] He maintains that "The fundamental weaknesses of NHS are the dominance of political decisions, the absence of built-in forces making for improvement and the removal of the test of the market."[33]

There is the possibility that, because NHS and many other federally sponsored programs of medical care are complete monopolies, innovation need not be encouraged and may even be curbed. With the absence of substitutes there are no strong external forces to encourage improvements in quality and efficiency. Economy can be stressed at the expense of better hospitals and equipment, better paid physicians, and the latest drugs and medical research, all of which represent increasing costs (and needs) in any program of public medicine.

4. Bureaucracy of Federal Control

Federal control usually entails a raft of paper work, much of which has been cut down or controlled, but which still remains an issue in evaluating a government program of medical care. Some "red tape" is inevitable and results in delays in answering requests, complicated and impersonal channels of communication and the general clumsiness of a giant operation. Some physicians claim that they have had to hire a clerk just to handle the administrative aspects of patient care.

5. The Patient's Perspective: Impersonality of Care

While the patients of those countries with nationalized medical care generally support their program with its attendant security and economy, they nevertheless find fault with the long waits necessary both at the hospital and in doctors' offices. When one finally does see a physician, they protest, his visit must be brief in view of the long line still waiting. The sheer magnitude of the patient rolls prohibits a doctor from providing the amount of personal care and attention which both parties desire. His role must necessarily be confined to that of a professional, no longer identified as friend and confidant in the fashion traditional for physicians.

It has been suggested that many people continue to seek private treatment, in programs where the alternative is given, because they resent having to wait hours for consultation and prefer calling for an appointment, they do not like being put in a ward of 20 or 30 patients with only screens for privacy, and they do not like being used as subjects for the training and teaching of medical students.[34] Patients, feeling a loss of personal attention to their needs complain that there is a minimum which the doctor must perform and that few go beyond this.

The fact that criticism and complaints alone have been stressed in this paper does not mean that they outweigh the amount of praise and success accorded these programs. It has been intimated already that the problems herein discussed are all rectifiable and very few of those complaining suggest that the system itself be abolished. On the contrary, the establishment of a closer liaison between the government-controlled administering agencies and the medical profession has resulted from the necessity of each to recognize, deal with and try to alleviate the problems, difficulties, pressures and needs of each of the two bodies. Greater sympathy, understanding and teamwork are emerging from the struggles of these conflicting interest groups, who, together, must shoulder the responsibility for the nation's medical care.

Many do think, however, that there should be a simultaneously operated private system (as exists in several countries now) to offer an opportunity for choice. This would provide a necessary incentive and stimulus for improvement and progress in the profession. In Britain a program has been requested where people can contract out, pay less in contributions and use the money saved to pay for their own doctor and other medical services. As the system stands now, any patient can pick any doctor under either private or public arrangement, but all must still contribute to NHS, so they would in effect pay twice if they desired private care. Many countries have compulsory insurance for certain income groups, above which the individuals have the option of remaining in the program or leaving it in favor of a private insurance program or none at all, at which time they need pay no longer for the federal program. This system has the dual feature of providing and insuring medical security for those unable to afford it alone, and free choice in the medical market for those who can afford it. Physicians also can combine the best elements of both programs.

As indicated in the introduction, this Report has attempted to outline some of the problems encountered under nationalized health programs. Insight into their causes may enable policy-makers in the United States to avoid the pitfalls which have created these problems and permit them to implement recently enacted legislation more efficiently.

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